State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Solano County Health & Social Services
Annual Report Program Year 2
4/2/2018

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting **(This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.)** **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

Whole Person Care

Solano County Health & Social Services

Annual Report Program Year 2

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I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

Community Connections, Solano County's Whole Person Care Pilot, has had continued successes in outreach and engagement. Since enrollment began in March 2017, Solano Coalition for Better Health (SCBH), the primary community provider and contractor, exhausted a list (received from Partnership HealthPlan of California (PHC)) of over 200 high-utilizers in addition to receiving indirect referrals from health providers. In September, a second high-utilizer list containing over 300 individuals was received. This resulted in an overall total of 79 (unduplicated) WPC clients enrolled for PY2, surpassing the target goal of 50 by 58%. As PHC's high-utilizer list is based from claims data over 60 days old, it was a challenge and lessons learned that the data may not always be accurate. Subsequently, future lists will no longer include certain mental health indicators, a critical component to identifying the pilot's target population (more information under Program Activities, Data sharing Section). Future steps will include coordination with the County's Fatality Review Committee to address the issue of deceased individuals listed and validating program eligibility criteria related to mental health.

Another success for the pilot is the emergence of a best practice model for WPC patients assigned to Family Health Services (FHS), Solano County's Clinics. This model heavily relies on the communication, collaboration, and interventions between SCBH's Care Coordinator and Community Health Outreach Workers (CHOW) and FHS Case Managers. Continuum of care is maintained through the weekly case conferences of which the FHS Case Managers are regular participants. A collaborative approach is used where conferences begin with a review of past and current care, diagnosis history, and medications. The Care Coordinator has positively expressed that this review ultimately helps to provide a sense on how to effectively treat the WPC patient. Characteristics of this successful partnership include the FHS Case Mangers being knowledgeable about system and local resources, being approachable, and flexible with SCBH staff and other team members.

However, efforts remain to ensure that behavioral health services as part of the care coordination are in place and not duplicated. It is unclear the best avenue for referring WPC clients who have a mild to moderate mental illness compounded with external factors such as the lack of psychiatric care. Coordinating mental health care is

exacerbated when extra precautions must be taken when sharing substance use information. Fortunately, a lesson learned has created clearer roles within the County Mental Health System and the County has made strides in data tracking. For example, all WPC clients are now red flagged in the system which provides the ability to monitor client referrals and activities. The County Mental Health system has also prioritized WPC clients and has provided walk-in capacity resulting in no waitlist for screening of mental health and substance use disorder services.

Overall, Community Connections has achieved two (2) of the three (3) performance outcomes as outlined in the grant agreement: Coordinated Care Plans within 30 days and Housing Services; surpassing the enrollment target, and have identified a best practice model within FHS's primary care setting. Areas of focus for PY3 will be continuing to navigate the mental health system, comprehensive review of care plans with the intention of graduating WPC clients, and using metrics and additional data for evaluation and sustainability.

III. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	0	0	*	*	*	*	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	*	*	20	*	11	79

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Service 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Whole Person Care

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FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Service 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A

For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed.

PMPM		Amount Claimed						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
TCP+	$454	0	0	$*	$6,356	$10,442	$13,620	$*
MM Counts 1		0	0	*	14	23	30	*
Bundle #2	$							
MM Counts 2								

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
TCP+	$454	$14,982	$17,252	$17,706	$26,786	$30,418	$34,504	$141,648
MM Counts 1		33	38	39	59	67	76	312
Bundle #2	$							
MM Counts 2								

Please provide additional detail, if any, about your enrollment and utilization for this reporting period. (Optional)

As reported at Mid-Year, enrollment totaled thirty-one (31) by the end of June; and PY2 has resulted in an overall total of 79 unduplicated clients served. The first top-high utilizer list included 174 individuals. The next iteration of top-utilizers listed over 300 individuals. An average of seven (7) clients are enrolled each month with the highest enrollment occurring in October.

The outreach rate necessitates further improvement since 50% of outreach efforts do not result in enrollment. However, once contact is made with clients, the rate of enrollment improves significantly. Of the engaged clients, approximately 83% have enrolled.

The CHOWs now maintain a client ratio averaging 1:20, compared to 1:5 at Mid-Year. Caseload is further managed based on acuity and for stepping down clients to lower levels of care as needed. The CHOWS also concurrently perform outreach and engagement to potential WPC clients (refer to CHOW Policies & Procedures). These services are included in the Per-Member-Per-Month (PMPM) under a single bundle.

Dis-enrolled Clients and Client Graduation
Out of 79 clients enrolled, a total of four (4) clients have dis-enrolled, this results in 75 active clients by the end of PY2. Unfortunately, the reasons for dis-enrollment were due to a client being deceased; and one being noncompliant. Provider make-up primarily includes those assigned to FHS but more recently have expanded to include WPC clients from NorthBay Healthcare, La Clinica de la Raza, and Community Medical Centers (CMC).

Next steps are now being discussed to graduate and/or step down WPC clients. A noticeable portion have successfully achieved the goals stated in their care

coordination plans and/or have maintained stabilized care and lower acuity. As described in the grant agreement, expected duration of services were expected to be twelve (12) months and the CHOWs and Care Coordinator have experienced shorter periods of active enrollment.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report.

As reported during Mid-Year, efforts have focused on onboarding staff, crafting policies and procedures, and inter-organizational relationship building. Solano Coalition for Better Health (SCBH) continues to deliver services through assertive outreach/engagement, care coordination, and meeting performance outcomes which often involves facilitating effective patient hand-offs among clinicians and providers. Nearly a year into operations, it became apparent that more investment should be spent in data-driven practices, updating policies and procedures, and capacity building.

A trend experienced in PY2 was an increase in staff transitions and turnovers; however, this has resulted in positive changes. SCBH is now fully staffed with a permanent Care Coordinator and Project Manager, along with an additional CHOW; Solano H&SS has enhanced its shared responsibility through an Epidemiologist and a Compliance/Quality Assurance Analyst to support the evaluation component and PDSA process. It is also important to highlight the significant progress made in ensuring policies/procedures coincide with WPC operations. As an update to the Mid-Year report, duties have leveled to less than 50% of the proposed budget.

Originally, H&SS elected to use Microsoft SharePoint for data information exchange, however, after the initial six months of use, it became clear that there were significant limitations in the ability to generate reports and track metrics utilizing the SharePoint system, and it was cumbersome to access client information. As a result, H&SS restarted the solicitation of product demonstrations from potential vendors, and selected Efforts to Outcomes (ETO) by Social Solutions. More information to be included under Program Activities, Data Collection/Reporting section.

The following policies and procedures are currently being updated and/or have already been updated:

- CHOW Policies and Procedures
- Updated Program and Eligibility Criteria
- Mental Health Policy
- Substance Use Policy
- Family Health Services Policy
- Care Coordination
- Outreach and Engagement

- Data Sharing/Reporting – coming soon

Navigating the complex regulatory landscape of client privacy and confidentiality has been a primary focus of Solano's Pilot and existing Federal and State Regulations (i.e. HIPAA, CMIA, 42 CFR Part 2) have presented challenges for participating partners, including understanding what information may be shared. There is a sense of hesitancy when it comes to sharing client information from all partners, but that's a good thing as we are focused on protecting our shared clients' privacy. However, the sense of hesitancy has presented challenges in adopting the new mentality that we are working within the constraints of a pilot and we are testing new ways of conducting business, which includes who we can discuss client information with and to what extent. With that, the innovative nature has allowed us to take steps forward in operationalizing new processes to review client releases periodically during client interactions to ensure the various elements in the Release of Information (ROI) form are clear in regards to what information may be shared, if the partners in multi-disciplinary care coordination meetings are authorized to be included in the conversation, if there are restrictions on the information we can share, and whether the ROI has expired or not. When 42 CFR Part 2 was finalized, we reviewed our ROI again to ensure the new guidelines were adopted and implemented. The new ROI is finalized and a formal training for the pilot partners will occur prior to releasing the ROI to the partners.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

Activities for PY2 has leveled out to less than 50% of the proposed budget.

July through September:
SCBH brainstormed ways to incentivize WPC eligibles to participate in in the program and outreach/engagement activities accelerated in the latter part of PY2. As part of outreaching to healthcare providers, SCBH continued to coordinate with NorthBay Healthcare, La Clinica de la raza, and Community Medical Centers.

October through December
Focus areas for the latter part of 2017 were utilizing the assessment/screening tool related to outreach and engagement. The Care Coordinator worked closely with the CHOWs to assign points for level of vulnerability. As WPC clients increased, efforts have concentrated on identifying gaps in the various referral process, particular within mental health. This has led to lessons learned in building data capacity and updating policies/procedures as the pilot experienced challenges related to the PHQ-9 metric and subsequently the Suicide Risk Assessment.

In learning the field environment, additional training was provided:

- Continuous Quality Improvement/PDSA Process; training provided to Care Coordinator and CHOWs by County Compliance/Quality Assurance Unit
- Homeless Outreach Best Practices and Engaging Vulnerable Populations; training provide by County Community Services Coordination Unit
- Solano County Coordinated Entry Program & using the VSPDAT screening tool
- How to Identify Intellectual Disabilities
- Assessing for Depression Beyond Interviewing

SharePoint continues to be used for documentation and tracking of clients, but towards the end of 2017, conversations have begun to transition to the ETO system which will be used by SCBH and the County.

VI. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

Not applicable.

VII. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

Comprehensive Care Plan within thirty (30) days of enrollment

PY2 Goal: 40 participants or 80% enrolled

A primary responsibility under the Care Coordinator includes establishing a comprehensive care plan near the onset of client interaction. This importance is then emphasized to the CHOWs and health providers. Once enrolled, procedures automatically begin with scheduling time for recurring care conferences. The CHOWs work to build relationships with the WPC client toward goal-setting and incorporating self-management, functional/social skills. Education on various resources and support programs is provided to the WPC client such as assistance in applying for social services.

As a result, Community Connections has successfully completed 84% of the comprehensive care plans on time, or plans for 68 out of the 79 clients, and has averaged 22 days between intake and formulation of a comprehensive care plan. In the last three months of the year, 100% of the plans were completed within 30 days. Next steps will include incorporating metrics to aide in faster reconciliation of care issues and clearer understanding of follow-up protocols. For example, the timely communication of ED visits and referrals.

Housing Services

PY2/Qtr3 Goal: Housing is provided or obtained for at least five (5) individuals; including prior quarter

PY2/Qtr4 Goal: Housing is provided for at least ten (10) individuals; Cumulative & unduplicated; including prior quarters. Outcomes are met if fewer than 10 need housing

Community Connections has been innovative in building housing inventory and operating under the Housing First model. The utilization of faith-based organizations, and hotels have been the primary safeguard. Future options include exploring subsidized housing units within the City of Fairfield and utilizing the units that are intended to be set aside for the County but are not currently available.

It is estimated that 34% of WPC clients are either homeless or at serious risk of homeless. SCBH provides clients 3 different levels of housing depending on the need and availability which are emergency/crisis, transitional and permanent housing.

As of December 2017, SCBH has provided the following:

- emergency housing for 11 clients
- transitional housing for 6 clients
- permanent housing for 9 clients

Total number of clients that have received some form of housing is 26. Some clients have received both emergency housing and then permanent or transitional housing. All of the 9 WPC clients who have received permanent housing continue to remain in their housing. Once housed, SCBH works closely with the client to develop housing plans, screening for public assistance programs, linkages, and established rental history.

Substance Use Disorder (SUD) Treatment Participation

PY2 Goal: Clients enrolled and participated in SUD treatment (unduplicated); 5 Participants or 10% Eligible.

Successfully linking clients to specialty care, particularly screening and identifying clients in need of mental health and substance abuse conditions, and motivating them to follow up on referrals, has posed a challenge. As a result, the number of referrals made and followed through on does not align with the large portion of high-cost utilizers experiencing a serious mental health condition(s). The Pilot is currently working on ways to solidify an enhanced criteria and referral process for mental health and substance use treatment. This performance outcome measure has not yet been met.

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

An update to stakeholder engagement includes frequency and format of regularly scheduled meetings. The sub-committee for the WPC/Operations Meeting was no longer needed and instead established:

(New) Data/Quality Improvement Committee: Membership includes County supervisory and management staff from SCBH and subject matter experts from County Health and Social Services. This committee aligns with Solano's grant agreement and serves as a vital resource to tracking, monitoring, and evaluating universal and variant metrics and performance outcomes.

WPC Steering Committee: Membership has adopted a new approach that includes providing accurate, timely, and relevant topics to "report out" to the Steering Committee members and other project leaders as appropriate. Staff contributions include committee updates, summary of successes and challenges, and "hot topics." SCBH distributes reporting out forms to members outlining expectation that all are to be prepared to orally present in addition to a verbal report. Some of the issues discussed include: concerns regarding how to serve undocumented individuals; clarifying the program and eligibility criteria; and the need to be familiar with the pilot's required metrics and outcome measures.

Planning and Operations Committee: Membership has expanded to include subject matter experts from County Health and Social Services as well as case managers from the different health providers. FHS case managers play an active role since the majority of WPC clients still are assigned to the County Clinics. Main topics include the referral and coordination process of primary care and behavioral health.

(New) WPC Project Meeting: Membership includes County supervisory and management staff form County Health and Social Services to include Public Health, Behavioral Health, and Administration. This serves to maintain open lines of communication among internal partners and discuss topics in response to updates and requirements from the Department of Health Care Services and advocacy groups.

Along with the change in technical infrastructure from the transition of SharePoint to ETO, a **(New)** WPC IT Committee meeting was established (more information to be anticipated for PY3 Mid-Year report)

IX. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.

(1) FHS Best Practice Model -
A success for the pilot is the emergence of a best practice model for WPC patients assigned to Family Health Services (FHS), Solano County's Clinics. This model heavily relies on the communication, collaboration, and interventions between SCBH's Care Coordinator and Community Health Outreach Workers (CHOW) and FHS Case Managers. Continuum of care is maintained through the weekly case conferences of which the FHS Case Managers are regular participants. A collaborative approach is used where conferences begin with a review of past and current care, diagnosis history, and medications. The Care Coordinator has positively expressed that this review ultimately helps to provide a sense on how to effectively treat the WPC patient. Characteristics of this successful partnership include the FHS Case Mangers being knowledgeable about system and local resources, being approachable, and flexible with SCBH staff and other team members.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.

(1) Limitations of potential WPC clients who are not Medi-Cal Eligible
Due to nuances in the PHC list, it became known that the CHOWs encountered many individuals who would greatly benefit from WPC services but unfortunately, were not eligible. The most common scenario being the limitations of support received for assisting undocumented immigrants. The Pilot determined that in the best interest of patient care, it would still attempt to serve those individuals but is aware that it would not be reportable nor reimbursable.

c.) Briefly describe 1-2 successes you have had with data and information sharing.

(1) Data Literacy
Ensuring all stakeholders were familiar with the required metrics was important to highlight in multiple venues and in more than one occasion. It was a challenge to become familiar with the metrics especially when there are varying interpretations from other pilots and the ambiguity from the technical specifications. However, it was a notable success when initiative was taken to increase data literacy to all partners. These included conducting a Metrics Meeting with SCBH and County staff, providing a summary sheet of the Pilot's universal and variant metrics to be shared at the WPC

Steering Committee and Planning/Operations Committee, and further linking those metrics with performance outcomes. Based on the success of the coordinated care plans performance outcome (administrative metric), future steps will be taken to emphasize the rest of the metrics in addition to introduction of the evaluation component.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.

(1) Effectiveness of the High-Utilizers List
Several false assumptions were exposed when utilizing the PHC list. It was assumed that all individuals included in the list met the Pilot's target population criteria. However, through the outreach and screening process, it was common to encounter individuals with no apparent mental illness, or at minimum no recent disorder. Iterations were made in reformatting the list to ensure that clients that met the criteria were sorted first.

Constant follow-up with PHC also had to be made in acquiring the next quarterly list. This was important considering that costs were based on claims data which makes it further outdated. More information to be included in PY3 Mid-Year on status of sharing agreement with PHC.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.

(1) SharePoint to ETO Transition
Originally, H&SS elected to use Microsoft SharePoint for data information exchange for the Whole Person Care Program. However, after the initial six months of use, it became clear that there were significant limitations in the ability to generate reports and track metrics utilizing the SharePoint system, and it was cumbersome to access client information. As a result, H&SS solicited a series of product demonstrations from potential vendors, and selected ETO by Social Solutions. ETO is a comprehensive outcomes and case management tool that allows data collections screens or forms to be added or modified easily. The ETO system will be designed to include an Outreach and Engagement Program to capture pre-enrollment activities, and a Whole Person Care Program to capture information once a client is enrolled. A benefit to both programs will be the ease with which reports can be run, and the capability to set alerts to notify staff when clients require follow-up services.

The process of preparing for the conversion from SharePoint to ETO has contributed positively to the clarification of policies and procedures, the streamlining of forms, and the specificity of questions and data elements collected. One of the first steps taken to

prepare for the conversion was to review all of the metrics required in the mid-year and annual reports with all involved partners and participants to discuss data collection processes and sources. During this meeting, the source of each data element was discussed, and who was responsible for collecting it. It was then determined whether or not it could be included in the ETO system, or if it would be maintained outside of the system. While the ETO system will be designed to assist with the WPC program and setting and meeting client goals, it is not intended to contain comprehensive medical record information. This meeting successfully established an understanding among partners of the need for data and information and clarified expectations for program delivery and data collection. Subsequent planning activities for ETO will include specifying program workflow, designing data collection screens to collect each activity, goal, or service, developing reports, and providing training.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

(1) The SharePoint system utilized in PY 2 stored data mostly in the form of uploaded documents, so there was no easy way to extract data back out of it when reporting was required without opening and searching through individuals text documents and forms. There was also a challenge in ensuring that all partners understanding their responsibility regarding data collection and reporting. Both issues have been addressed and significant improvements are expected in PY3.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?

Access to mental health providers – Mental health is repeatedly identified by the Solano community as the most significant health issue in Solano County. WPC seeks to link clients with resources, however, there continues to be a shortage of sufficient providers to rapidly meet the needs of individuals with mild, moderate and severe conditions.

Lack of Housing
Although SCBH was innovative in securing housing services for WPC clients, external factors such as living in a compressed housing market still remain. Considering the Atlas Fire that occurred in October, it compounded the issue with potential WPC participants, but fortunately did not directly affect those clients enrolled.

Engagement with managed care plan and hospitals
Though stakeholders include representatives from the local hospitals, until the Pilot demonstrates and adequate return on investment, sustainability in the program is still unclear. This would be accomplished through continuous communication of the Pilot's

overarching goals, overcoming legacy obstacles, and reframing the person-centered model of health care.

X. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

List PDSA attachments

- Data and Information Sharing (1 of 2)
- Data and Information Sharing (2 of 2)
- Care Coordination (1 of 2)
- Care Coordination (2 of 2)
- Comprehensive Care Plans (1 of 2)
- Comprehensive Care Plans (2 of 2)

Per communication with DHCS, the following PDSA have been approved to be extended to April 16th. The Pilot will submit the two remaining PDSA in accordance to the new timeline of the Variant/Universal Metrics.

- Ambulatory Care
- Inpatient Utilization